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CASE HISTORY TAKING
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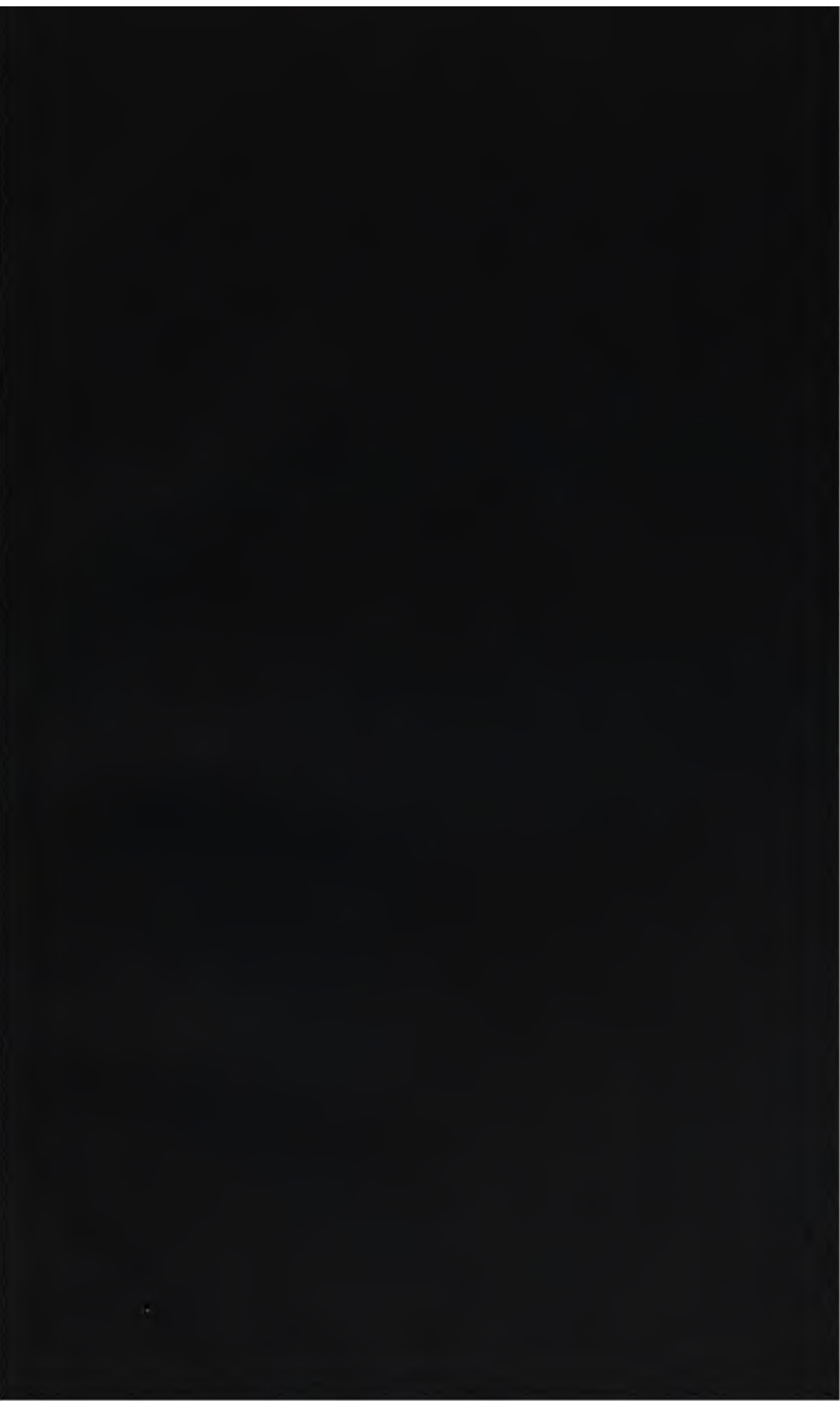
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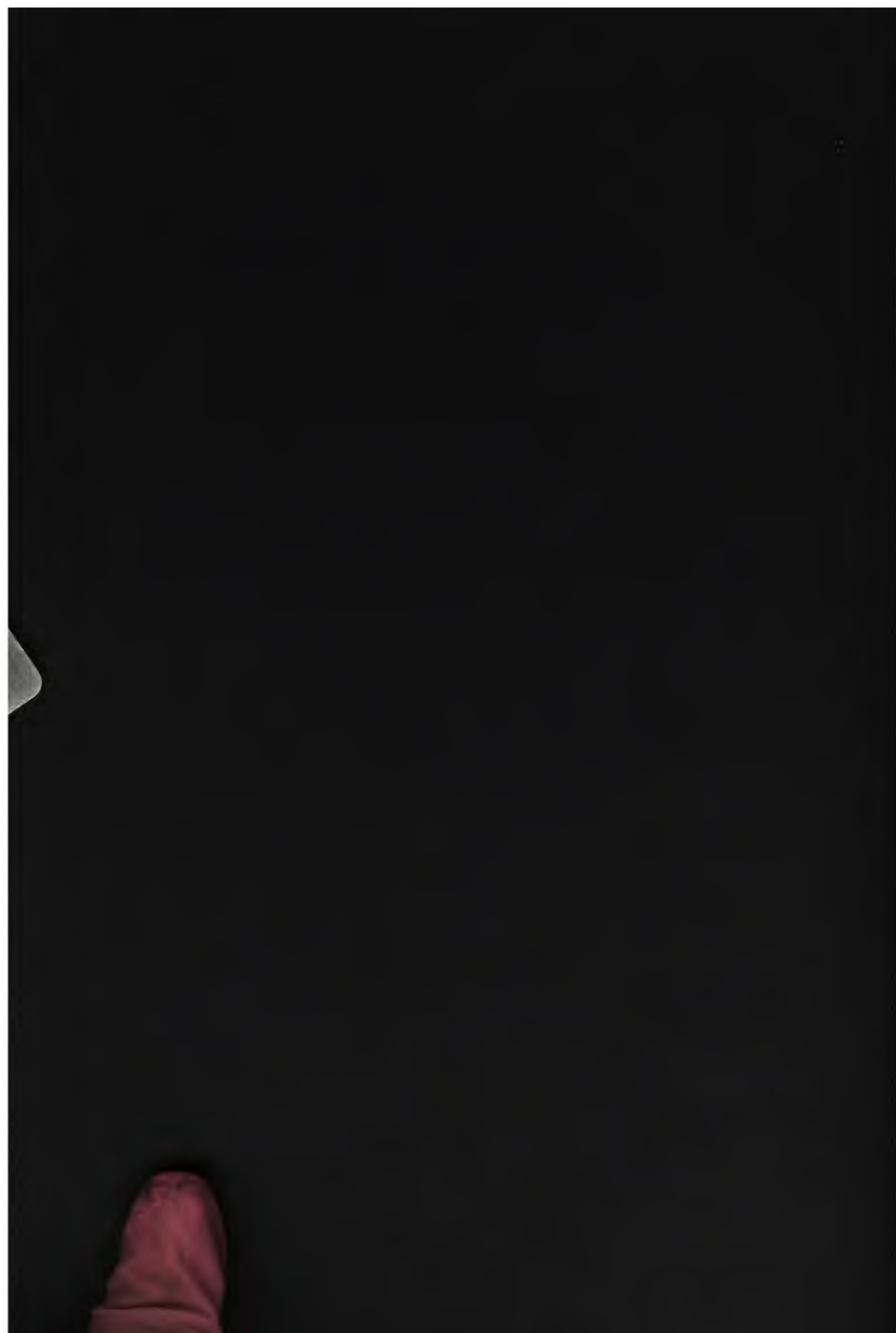
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**THE PRINCIPLES OF
CASE HISTORY TAKING**

THE PRINCIPLES OF CASE HISTORY TAKING

By
ARTHUR F. BYFIELD, Ph.B., M.D.
CHICAGO



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1921

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PREFACE

The scope of this volume is as modest as its purpose. The latter we have accomplished if we have demonstrated that case-history writing ought to be regarded not as an *incidental*, but as an *essential*—if not the most vital—element in the building of a diagnosis. We hope to have shown, in other words, that the subject is of such great importance as to merit a place, not, as has heretofore been true, in the introductory pages of a volume on physical diagnosis or clinical diagnosis, but in a setting of its own.

It has not been our aim to write the last word on the subject—we recognize that many of the points we have brought forth for consideration might have been much more completely elaborated. It is our hope, indeed, that this volume contains just enough to lend to the topic the dignity it deserves, thereby stimulating further and more detailed work along similar lines.

If this hope is gratified, we may look forward not only to a more general writing of case histories, but to some standardization of the method of preparing them; to histories which shall have real statistical value; and to a lifting of the niveau of diagnostic accuracy.

ARTHUR F. BYFIELD

Chicago, Illinois

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THE PRINCIPLES OF CASE HISTORY TAKING

CHAPTER I

GENERAL CONSIDERATIONS

A first-class history is a necessary prelude to a first-class diagnosis; in some cases, indeed, a well-elaborated anamnesis practically establishes the diagnosis. The converse is equally true—a history, written hurriedly and aimlessly, composed of data not properly digested or analyzed, is not only valueless but often highly misleading.

Case-taking is both an art and a science, and reflects to the very highest degree the skill, judgment, tact and breadth of clinical experience of the recorder—particularly the latter, one may say, as it is only on the basis of a fairly ripe experience that a really valuable case history is possible.

To the medical student just launched upon his clinical years this may sound discouraging. He may wonder how, with only the most meager bedside experience to support him, he can pretend to prepare a satisfactory medical history. Until recent years, indeed, such a question would have been fully justified, as the methods of teaching medicine formerly in vogue—and in too many schools at the present date—permitted the medical student but little personal and responsible contact with the patient. The result of these older methods was that, with but few exceptions—the brilliant clinicians and teachers who understood the indispensable aid offered by a properly written history, and who laid emphasis upon the principles of the subject—the student graduated with only an occasional hint relative to case-taking, in the dispensary or clinic, and too often with not even this hint. These men, as practitioners, were apt to disregard the value and importance

of a history altogether and to make use of slipshod methods, to which reference will be made later.

In the better schools this has, to a large extent, been changed. The patient is given to the student *as a case*, in his clinical years, and, by means of clinical clerkships in the dispensary and hospital, and of small bedside clinics, he is expected to develop a diagnosis from beginning to end. It need not be said that proper instruction presupposes a careful supervision, on the part of those in charge of such work, not only of the diagnostic routine, but also of the details of the anamnesis.

In brief, it may be said without exaggeration that the character of a medical school may be gauged with a very fair degree of accuracy by the caliber of the histories written by its graduates; while, in the case of the man in practice, it is not difficult, on the basis of the kind of history he prepares, to estimate not only the character of his early training, but also the breadth of his subsequent clinical experience.

The graduate of the higher type of medical school is, in still other ways, better equipped from the outset to write a good case history, thus compensating to some extent for the experience and judgment that come only with years. We refer first to the fact that some schools include in their curricula didactic work on the preparation of medical histories—this being the subject, primarily, of this volume—and, secondly, to the fact that in the more advanced colleges the student is so thoroughly grounded in pathology and pathologic complexes that he is in a position, as will appear in the following pages, to direct his questions to the patient in such a manner as best to develop the data essential to a diagnosis.

The well-trained student—one who has had some grounding in the fundamentals of what constitutes an acceptable history, and who, under proper instruction, has had a fair opportunity of applying these fundamentals in actual clinical work for which he is held responsible—will not find it altogether

difficult to separate the valuable from the worthless in case histories. This difference is by no means one of length, as so many seem to believe; *brevity*, indeed, when combined with the faculty of searching out the important and of analyzing the same, is one of the *prime essentials of a good history*. The uninstructive anamnesis is one, the only merit of which is that it adheres to a set outline: symptoms are jotted down and left hanging, as it were, without coherence and co-ordination in the fabric as a whole; invaluable diagnostic points are omitted, either because the questioner is too inexperienced to ask salient questions, or because one or more answers of the patient have caused him to pass premature judgment upon the case.

A history becomes increasingly valuable as it aids in the making of a diagnosis. It is true, as we shall see later, that a definite scheme is necessary in the routine of obtaining the patient's story; but, aside from this guiding outline, each anamnesis should have its individualistic stamp. Just here lies the pernicious influence of the all too general habit of employing printed outlines in which a fixed space is allowed—determined to some extent by the printer and also by the size of the card or sheet employed—for the recording of the several subdivisions of the history. A worth-while anamnesis, brief and to the point though it must be, cannot be cramped within set confines. In some cases, the *complaint upon entrance* may demand only a few lines and the recording of *previous illnesses* half a page. How, then, can one do oneself or one's patient justice under the restrictions of printed forms such as are all too commonly employed (Fig. 1)? The chief justification for using them would seem to be that they are a sort of prop for the student or physician who has had no adequate instruction in the writing of histories, and whose training has led him to regard the patient as a case, not as an individual.

While discussing the matter of stereotyped forms for the writing of the history proper, we may at this time conveniently

call attention to a no less objectionable custom of employing "cut and dried" outlines for the recording of the physical and laboratory examinations (Figs. 1 and 2). The particular card chosen to illustrate this point, although possibly an exaggerated example, possesses the objections common to all such forms: first, that they arbitrarily limit expansion where expansion is necessary, and secondly—particularly in the case of the more elaborate forms—that they suggest a routine for examination which is rarely called for in an average case. It is not necessary, for instance, when a patient from a malarial region presents himself with a history of regularly recurring chills, fever and sweats, to determine whether his auditory canal contains inspissated cerumen, or whether his sense of co-ordination is normal, in order to fill in the spaces devoted to these questions on some cards of this character. Occasionally, one encounters a case in which all of these minutiae must be observed; as a rule, however, the patient's story, carefully analyzed, should serve as a guide to the course of the physical examination. (By way of contrast with Figs. 1 and 2, see Fig. 3).

The author does not for an instant wish to give the impression that a *thorough* examination should not be made in every case, no matter what the complaint. What he does intend to convey is that the history sheet, in addition to points essential to every examination, should not contain a mass of irrelevant material such as would necessarily be embodied in a printed form applicable to all cases. It adds nothing to the findings in a clean-cut case of duodenal ulcer to have noted upon the sheet in the blank reserved for eye-muscles that the latter are normal.

A complete, but not padded, history and examination are necessary in every case. It may also be noted that, although the major part of what is to be said here applies with especial emphasis to medical cases, it is true to a scarcely less degree that a full history and a thorough *general* examination are

No.	Case	Diagnosis
Name.....	Age.....	Nat..... Dom. Rel..... Occup.....
Family History		
Personal History		
Habits.....	Alcohol.....	Tobacco..... Venereal.....
Previous Diseases.....		
Present Complaint.....		
Status Praesens. Weight..... Height..... Temp..... Resp..... Pulse.....		
Physical Exam.		
Facies. Eye.....	Conj.....	Pupil..... Light React.....
	Ocular mov.....	Accom..... Conv.....
Mouth.....	Tongue.....	Teeth.....
Pharynx.....	Tonsils.....	Thyroid.....
Glands.....	Sub. Max.....	Cerv..... Axil.....
Lungs.....		Cubital.....
Inspection.....	Right	Left
Apices.....	ANT. POST.	ANT. POST.
Boundaries.....		
Adhesions.....		
Percussion.....		
Palpation.....		
Auscultation.....		

FIG. 1.—CARD ILLUSTRATING A POOR METHOD OF RECORDING THE MEDICAL HISTORY AND THE DATA OF THE EXAMINATION.

Records of this type are in very general use, but are practically worthless.

necessary in surgical, gynecologic, dermatologic and other conditions. There is nothing truer in diagnosis than this: The average physician who prepares a careful history and makes a complete routine examination will arrive at a greater number of correct diagnoses than will his more brilliant colleague who glides over the patient's anamnesis, makes a snapshot diagnosis on the basis of the incomplete information he has received, and directs his physical examination along the lines of his premature judgment.

Accuracy is, of course, one of the prime essentials of a history which is of value, and a great many factors enter into consideration in this connection. In the first place, one must allow oneself sufficient time. To attempt to cut short the anamnesis, because one is busy, leads to two things—a loss of the very necessary meditative aspect on the part of the physician, and a hindrance to the full play of the patient's memory. On the other hand, the voluble patient, once his peculiarities are understood and appreciated from the point of view of their diagnostic significance, should, by tactful counterquestion, be interrupted in order that time should not be wasted.

In the matter of accuracy, further, it is obvious that the examiner must be conversant with the language of the patient. Little difficulty will be encountered on this score in the average practice, for if a physician hangs out his shingle in a community where a foreign tongue prevails, it is almost a *sine qua non* to know that tongue. In the larger general hospitals, however, every known language is encountered at one time or another. The custom obtaining in certain institutions of preparing translations into various tongues of the commoner questions essential to the obtaining of a history is not a wholly commendable one, in that the questioner limits himself to the questionnaire and thus often fails to obtain vital facts. In a great many cases relatives or friends who speak English accompany the patient and render the task easy. When an

official interpreter is not at hand, one must avail oneself of the linguistic accomplishments of other patients.

The physician will often be surprised to find that histories obtained in the presence of relatives or friends differ radically from those volunteered when the examiner is alone with the patient. Experience and a natural talent for reading mental processes will in part suffice to determine whether or not the patient is "holding back"; as for the rest, inconsistencies in the history as first obtained and in the results of the clinical examination must serve to put one upon the right track. In venereal and sexual cases it is advisable to postpone questioning until there is opportunity for private conversation.

The judgment of the physician must also determine when a history is likely to be inaccurate because of the physical condition of the patient. In many cases, although the patient is gravely ill, his answers will seem to indicate a clear sensorium. If the replies are satisfactory and dovetail properly, well and good; if not, recourse must be had to those about the sick person.

Tact and delicacy are prerequisites to an accurate anamnesis in many cases. By this is not meant a foolish reserve in asking necessary questions, but avoidance of that brusque, dictatorial manner which tends to place many individuals upon their guard and to make them actually secretive. It is a quite inexplicable frame of mind which prompts a person to consult a physician and then to conceal from the latter vital information; however, this is not at all infrequently the case. Although we must be gentle and sympathetic with patients of all types, whatever their symptoms may be, we need hardly say that these qualities are especially essential in the case of

FIG. 3.—A FOUR-PAGE HISTORY FORM, WHICH, THOUGH RIGID IN SOME WAYS, POSSESSES MANY OF THE POINTS COMMENDED IN THE TEXT.

In the several subdivisions of history and examination, a reasonable amount of space is left for expansion, and the latter, with subsequent notes, can also be taken care of on the third page. The laboratory page is excellent.

DR. HOWARD A. SMITH
CHICAGO

No.	Patient's No.:	Date:	Sex:	Age:	M.S.W.
	Name:		Color:	Nationality:	
	Residence:		Occupation:	Gain:	
			Height:	Weight:	Loss:
	Present Complaint:			Since:	

Family History:	Father, l. health:	d. cause:	Brothers: l.	d.
	Mother, l. health:	d. cause:	Sisters: l.	d.
	Family tendencies:			

Previous Health: Childhood, adolescence; women (menstruation, pregnancies, miscarriages, pelvic infections); diseases (rheumatism, lues, gonorrhea, etc.); accidents, operations.

NAME	Habits—environment:	Bowel movements; work; wages; dwelling; bedroom; usual food; daily habits (work, rest, amusements, sleep); tea; coffee; tobacco; alcohol; drugs.
------	----------------------------	--

History of Present Illness: Duration; progress; onset; earliest symptoms; most troublesome symptoms; physical changes observed; former treatment.

General Inspection:	Appearance:	Temper-	Pulse:	Respiration:
	Development—nutrition:	ature:	Glands:	
			moist:	dry:
	Mouth—throat teeth:	Eyes:	Skin: trauma:	scars:
			eruptions:	edema:

Diagnosis: Provisional:	Final:
--------------------------------	---------------

GENERAL EXAMINATION

Digestive Tract:

Respiratory Tract:

Circulatory Tract:

Genito-urinary Tract:

Nervous System:

Date

DETAILED HISTORY

LABORATORY REPORTS					
Date at top of each column					
URINE:	19	19	19	19	19
Quantity					
Appearance					
Reaction					
Specific Gravity					
Albumin					
Sugar					
Indican					
Sediment					
BLOOD:	19	19	19	19	19
Hemoglobin					
Erythrocyte count					
Leukocyte count					
DIFFERENTIAL <small>State No. Cells Counted</small>					
Polymorphonuclear					
Lymphocytes					
Large mononuclears					
Transitionals					
Eosinophils					
Basophils					
SPECIAL LABORATORY EXAMINATIONS:					

diseases of the sexual organs and in those involving the genitalia, for this seems to many individuals to be a field in which the physician is not entitled to know everything. It is in this field that the examiner can find full play for a tactful question, aimed here and there, with the result that all necessary information is soon at his disposal.

Of all the essentials to accuracy in history-writing, however, none is so important as a thorough analysis of the patient's symptoms, past and present. It is just here that the physician's skill and judgment are put to the severest test. To one man the symptom *pain in the stomach* means only that; to another who can analyze and correctly develop the facts bearing upon this manifestation, it means quite another thing—perhaps a tentative diagnosis. The term *chill* as given by the patient signifies relatively little unless an effort is made to bring out information as to its severity, duration, periodicity, etc. And *rheumatism*—there is surely no condition more frequently mentioned in the patient's recital or more often incorrectly named! Careful analysis should quickly demonstrate whether the pain is—or was—articular, muscular, or of another nature, whether it was associated with fever, whether it involved one or many joints, whether or not it was severe enough to confine the patient to his bed, whether or not it was associated with swelling and redness of certain joints and was accompanied by drenching perspiration, and so on. Rheumatism, unqualified, means little; rheumatism defined and properly qualified may determine the diagnosis.

This matter of the thorough analysis of all points in the patient's story applies with equal emphasis to all of its details—*present complaint, past illness, etc.* (see also p. 33). In many cases a history so taken and analyzed will enable one to make a highly probable diagnosis even before the examination is begun (pneumonia, duodenal ulcer, acute poliomyelitis, appendicitis, etc.); in all cases, it is a necessary prerequisite to an intelligent study of the patient as an individual.

CHAPTER II

MATERIALS

Before entering upon the subject of history-writing proper, it may be well to deviate from our principal theme for a moment in order to say a few words about suitable materials upon which to record histories and about commendable methods of preserving them. Although the recording and keeping of the hospital and dispensary histories should, in the main, follow the suggestions about to be made, the author's recommendations are intended for the needs of private practice.

Compactness, though axiomatic of modern business methods—and such have a distinct place in the keeping of medical history records—cannot be emphasized at the expense of serviceableness. The use of printed forms with definite space allotments for the items of the history and the physical and laboratory findings has already been sufficiently condemned. Cards or paper, blank except for captions such as name, date, occupation, address, place of birth, diagnosis, etc., are much less objectionable, as there is no restriction to the space which may be occupied by such features of the anamnesis and examination as may require expansion. The disadvantage in the use of any but very large cards (8x10 inches, or larger) is chiefly one of bulk, for as the record grows with subsequent examinations of the patient and repeated laboratory tests, a rather unwieldy and space-consuming collection is the result. Another not entirely negligible objection to the use of cards is the matter of expense. Furthermore, when cards are employed, the tendency is to intermingle physical and laboratory data, a method which, as will be pointed out in detail later, detracts from serviceability in the matter of future reference. If, despite these disadvantages, cards are made

FIG. 4.—A FOUR-PAGE TYPE OF CASE HISTORY FORM RECOMMENDED BY THE AUTHOR.

DR. HOWARD A. SMITH
CHICAGO

No. _____ Date _____ Referred by _____

Name _____ Address _____

Occupation _____ Age _____ Place of Birth _____

Provisional Diagnosis _____

Definitive Diagnosis and Outcome _____

Present Illness:
Onset and
Course

Previous
Illness:

Habits and Routine:	
Family History:	
Venereal; Menstrual:	
Examination: (Various subheads of the examination may be inserted in this margin.)	

**Subsequent
Data:**

(Insert dates in
this margin.)

LABORATORY	
Urinalysis	
Date (Original) _____	
(Place dates of later examinations in this margin.)	
Blood	
Date _____	
X-ray	
Date _____	
Stool	
Date _____	

use of, they had better be of ordinary letterhead size ($8\frac{1}{2} \times 11$ inches) for reasons described below. The statistical information essential in every case—name, residence, age, occupation, etc.—may either be written at the top of the card in long hand or, better, printed just as in the case of the paper records about to be described. (For methods of filing cards and other types of records *see* page 24).

For reasons which will appear, the author believes that a history sheet closely following that shown in Fig. 4 best fulfills the various demands made upon such forms. It consists, as will be noted, of four pages, the page size measuring $8\frac{1}{2} \times 11$ inches. The only printed items should be those above the horizontal line on the first page—which may, of course, be just as acceptably inserted in long hand—*Present Illness: Onset and Course*, just below the line on the same page, and *Laboratory* on the fourth page, which should be printed, as it serves to confine the laboratory data to this page. The other marginal captions: *Previous Illness*, *Habits and Routine*, *Family History*, *Venereal*, *Menstrual*, *Examination*, and *Subsequent Data* are inserted in pen and ink where the demands of the history and examination place them.

Under the subhead *Examination* may be written in, if desired, the several phases of the examination, such as *General*, *Head and Neck*, *Pleura and Lungs*, *Heart and Vessels*, etc.; while under *Subsequent Data* are placed the dates on which later examinations are made. On the page devoted to *Laboratory*, the different forms of the latter—*Urinalysis*, *Blood*, *X-ray*, etc.—may be written in the margin, or rubber stamps may be employed for the purpose, a method which the writer finds very convenient and satisfactory. In either case the various groups of laboratory work should be so spaced—based with a reasonable degree of accuracy upon the particular type of case—as to allow ample room for subsequent examinations, the dates of the latter appearing in the margin beside the data.

URINALYSES

BLOOD

20

STOMACH CONTENTS

[illegible]

STOOLS

[illegible]

FIG. 5.—EXAMPLES OF LABORATORY FORMS.

These forms contain relatively few of the objections mentioned in the text. The reverse side of the sheet on which all four forms are printed may be used for other similar forms or may be left blank with the marginal caption: "Other Data; Special Data."

Several modifications of the plan just described work out very well in practice. In the first place the history form may be made up of six pages instead of four, with the idea primarily of allowing sufficient space for the demands of practically every case. (In the four-page scheme additional pages of letterhead size may be inserted as needed.) Or the middle sheet of the six-page type may be reserved for laboratory data, thus providing for the latter two pages, instead of one. The middle, laboratory sheet—pages 3 and 4 of the six-page booklet—may be left blank except for the caption *Laboratory* at the top, and the ruled margins; or special forms for the examinations of a more routine nature may be printed thereon (Fig. 5). The objections to such printed forms are the same as those already directed against printed history and examination cards—they go far beyond the routine required for the average case and they are likely to prevent expansion when this becomes necessary. The particular case, for example, may demand twenty urinalyses to one hematologic examination, and yet a set form would allow about equal space for each.

Still another modification of the four-page form which has much in its favor is the use of special pages, of the same size ($8\frac{1}{2} \times 11$), for the different laboratory examinations, such pages to be fastened within the booklet by metal clasps. These additional pages should follow, in general, the forms shown in Fig. 5 and not those of the type of Figs. 6 and 7. For easy identification, different colors of paper may be used for the different laboratory examinations, but, in order to prevent undue bulkiness, two, or even three, subjects may be included on a single page, somewhat after the plan suggested in Fig. 5. At the top of each laboratory page appears the number of the

FIG. 6.—AN UNSUITABLE FORM FOR RECORDING BLOOD EXAMINATIONS.

There are repeated examinations of the blood in a given case, and, as each sheet can be used for only one examination, there will be a consequent bulky accumulation of such sheets and comparison of the records of different dates will be difficult. (See the forms shown in Fig. 5.)

EXAMINATION OF BLOOD

RED BLOOD-CORPUSCLES—

No. per cu.mm. _____ How estimated _____

Poikilocytes _____ Normoblasts _____

Megalocytes _____ Megaloblasts _____

Microcytes _____ Microblasts _____

Granular degeneration _____ Polychromatophilia _____

LEUKOCYTES—

No. per cu.mm. _____

Differential count _____

Lymphocytes _____ per cent.

Large Mononuclear and Trans. _____ “

Polymorphonuclear Neutrophils _____ “

“ Eosinophils _____ “

“ Basophils _____ “

Neutrophilic Myelocytes _____ “

Eosinophilic “ _____ “

Stimulation forms _____ “

Undetermined _____ “

Hemoglobin _____ per cent. Instrument _____

Specific gravity _____ (_____ % Hb. Hammerschlag table)

Color index _____ Volume index _____

Coagulation time _____ Blood platelets _____

Blood Cultures (Media _____)

Animal Parasites _____

Serum reactions _____

Miscellaneous _____

history and the name of the patient; and each laboratory phase—*Urinalysis*, *Blood*, etc.—is properly labeled.

The number of these colored laboratory forms which may seem desirable will vary greatly; the physician in general practice will find two or possibly three such combination pages sufficient for all routine examinations. The specialist, on the contrary, will require forms suitable for particular purposes: fields of vision, renal functional tests, diabetic charts, fractional gastric analyses and so forth; however, to attempt to reproduce, or even to discuss these various special forms is not within the scope of this work.

The letterhead size of page recommended in the various history forms and extra pages just described is preferable to other sizes, not only because it affords sufficient space for nearly every purpose, but because correspondence relative to the case may be neatly and compactly filed away with it. The habit of stuffing cards and papers of various sizes in an envelope as a container for the records of each individual case detracts from system in the keeping of records. It is the author's custom to place five histories in a stout Manila container, open at the top, and with a flap for the numbers of the records contained.

We come, finally, in the matter of materials, to methods of filing histories and of cross-indexing. Here again no attempt will be made to describe the many eminently satisfactory methods designed for this purpose. Any system which readily enables the physician to find the particular history he wishes is satisfactory provided that, as the number of histories grows, the system does not become unwieldy. The alphabetical filing of records does become extremely unsatisfactory after a time, inasmuch as one finds it necessary to run through a certain number of histories, no matter how well subdivided the alphabet may be.

FIG. 7.—AN UNSUITABLE FORM FOR RECORDING URINALYSES.
(See note in explanation of Fig. 6.)

EXAMINATION OF URINE

ROUTINE COMPLETE EXAMINATION

Sp. gr. Reaction

Color Quantity $\left\{ \begin{array}{l} \text{Single} \text{} \\ \text{24 hrs.} \text{} \end{array} \right.$ Consistency

Sediment Cloudy Odor

Albumin Sugar

Acetone Diacetic Acid

Casts R. b. c.

W. b. c. Other Cells

Crystals Amorphous

Miscellaneous

SPECIAL QUALITATIVE EXAMINATIONS

Mucin Bile Indican Hb.

Diazo Glycuronates Cammidge

Drugs Miscellaneous

Other reducing substances Other Albuminous bodies

Bacteriologic

SPECIAL QUANTITATIVE EXAMINATIONS

Sugar (kind Test Sol.) per cent.

Albumin (Method) per cent.

Total solids (..... coefficient) gms. per liter

Total N (Kjeldahl) gms. in 24 hrs. Ammonia (NH₃) gms. 24 hrs.

Urea (..... Method) gms. in 24 hrs. $\frac{N - NH_3}{\text{Total N}} =$

Uric Acid (..... Method) gms. in 24 hrs.

Other nitrogenous bodies (..... Method) gms. in 24 hrs.

Acetone (..... Method) gms. in 24 hrs.

Phosphates (..... Method) gms. in 24 hrs.

Chlorids (..... Method) gms. in 24 hrs.

Sulphates (..... Method) gms. in 24 hrs.

Distinctly preferable, in the author's opinion, is the numerical file. Reference to Fig. 4 will show that each anamnesis is numbered, the number on the history corresponding to a number on a card in a small card index system. The small card bears in addition the name of the patient and either the diagnosis in the case—for a quick study of records—or ledger rulings for that phase of practice. The ideal containers for histories and card indices are the metal files with drawers of the necessary sizes, as a safeguard against loss by fire.

CHAPTER III

THE HISTORY PROPER

Mention was made on an earlier page of the necessity of employing some skeletal outline in the writing of the history proper, upon which the individualizing details of the particular patient's story should be built. These main divisions, which are more or less stereotyped and appear under one name or another, with some variation in sequence, as a part of practically every history, are the following:

- (1) Present illness.
- (2) Previous illness.
- (3) Family history.
- (4) Patient's daily routine; frequently called habits, or personal history.
- (5) Venereal history. This appears to better advantage, perhaps as a special subhead than as a part of Previous illness.
- (6) Menstrual history in the case of women.

Present Illness.—While the history is being written the patient should sit, or lie, facing a good, although not intense, light in order that the physician may study the sick man's facial expressions, and, generally, his manner of telling his story. To the observant, and especially to the experienced examiner, a considerable amount of information is given in this way, as regards the reliability and weight of the statements made and in general as to the mental makeup of the patient. The trained and attentive ear and eye, unaided by instruments, note a wealth of diagnostic material, some of the details of which are mentioned in the following chapter.

In the matter of developing the *present complaint*, as in the case of practically all other subdivisions of the history, there

is a considerable choice of method. Although half a dozen or more satisfactory forms of procedure might be mentioned, the author will, to avoid confusion, confine himself to a discussion of two only. Later on, with a growing experience, the student will very probably evolve a method more satisfactory for his purposes than are those offered here; however, at first, it is advisable that this experience be gained along one or the other of the two lines to be mentioned.

In the first method of developing the present complaint, each symptom as it is given is taken down and analyzed—the explanation of this term will be considered at length a little later (page 33)—from its onset to the time when the patient presents himself. A slight variation of this method is to enumerate the list of symptoms at the beginning, following which each complaint is considered in detail (Fig. 8).

In the second method—the one especially recommended by the author—the patient's complaint is considered under the following subdivisions:

(1) *The onset* of the trouble, including the duration of the latter, its earliest manifestations and a résumé of any previous attacks.

(2) *The course* of the illness since its onset (most recent exacerbation if there have been previous attacks; the latter are considered under 1).

(3) *The present status* of the process, representing the condition of the patient when he presents himself for examination. (Fig. 9.)

The plan just considered has the advantage over the first of placing symptoms side by side in their time relationship. In the first plan, a certain loss of perspective is bound to occur because of the seriatim analysis of each symptom from beginning to end.

FIG. 8.—ILLUSTRATION OF THE FIRST METHOD OF DEVELOPING THE "PRESENT ILLNESS" OF THE PATIENT.

The résumé at the beginning may be omitted, but is recommended for quick orientation.

DR. HOWARD A. SMITH
CHICAGO

No. 642 Date 8 24 15 Referred by _____

Name Williams, George Address 1011 A Street, Chicago

Occupation Bond Salesman Age 25 Place of Birth Chicago

Provisional Diagnosis Typhoid Fever

Definitive Diagnosis and Outcome Typhoid Fever; Myocardial Degeneration.
Recovery (Complete?), 2 18 17.

Present Illness:
Onset and
Course

This began about ten days ago; there has been no previous illness of a similar nature.

RÉSUMÉ OF SYMPTOMATOLOGY SINCE ONSET OF TROUBLE:

Headache
Cough
Loss of Appetite
Weakness
Disinclination to work
Fever
Constipation
Nosebleed
Abdominal Pain

SYMPTOMS IN DETAIL:

Headache:--This was one of the earliest symptoms noted and is still present, although not so severe. The patient has never been troubled with headache in the past. The pain is chiefly frontal and is present more or less throughout the day except for brief intervals after taking aspirin. Pressure does not aggravate the discomfort; heat relieves it somewhat.

Cough:--The patient began to cough soon after the headache appeared, and has coughed more or less constantly throughout the day since. In the last few days there has been some improvement. Small amounts of thin, whitish sputum; no blood.

Loss of Appetite:--There has been little inclination to eat since the very onset; no kind of food is tempting. No symptoms on the part of the stomach.

Previous
Illness:

The ideal method in the preparation of a case history is to take notes as the information is gathered and then to write the history in its final form. This plan makes for coherence, compactness and a logical arrangement. With a growing experience, however, the physician does not find it unduly difficult to write a good history as he questions the patient; and for the busy man who takes his own histories, this is the only practical method. Nevertheless, the best of men will find, despite due care in the gathering of symptoms, that it will be necessary not infrequently to "fill in" at one or more places in the patient's recital—this applies not only to the present complaint, but also to the other subdivisions of the history—because of further questioning called for by facts brought out either in subsequent parts of the anamnesis or in the examination of the patient.

At this point it seems advisable to consider in some detail features which concern all subdivisions of the history proper but more particularly, perhaps, the substance of the present complaint. The author refers to the matter of *the correctness of the replies made by the patient to our inquiries* and to *the analysis of the symptoms* given by him. In questioning the accuracy of his replies, no reflection is necessarily cast upon his veracity. Misleading answers, as the experienced physician knows, are due to several factors, among which are the carrying about by the patients themselves of careless or inaccurate diagnoses made by former physicians, medical advice given by non-medical friends, the reading by the patient of "quack" advertisements, and ignorance. Untruthfulness does, of course, at times enter in as a factor.

No term is perhaps so loosely employed by the patient as is *rheumatism*, which is used to cover such dissimilar conditions as tuberculosis of bones and joints, the lightning pains of tabes dorsalis, true rheumatic fever, trichinosis, gout and

FIG. 9.—THE SAME CASE HISTORY AS IN FIG. 8, ARRANGED ACCORDING TO THE SECOND METHOD OF DEVELOPING THE "PRESENT ILLNESS."

DR. HOWARD A. SMITH
CHICAGO

No. 642 Date 8/24/16 Referred by _____

Name Williams, George Address 1011 A Street, Chicago

Occupation Bond Salesman Age 25 Place of Birth Chicago

Provisional Diagnosis Typhoid Fever

Definitive Diagnosis and Outcome Typhoid Fever; Myocardial Degeneration,
Recovery (Complete?), 2/18/17.

Present Illness:
Onset and
Course

ONSET.--The present complaint--no previous similar trouble--began about ten days ago with headache, cough, loss of appetite and nosebleed. The headache, which was probably the first symptom noted, was very severe, the more so as the patient has never suffered from it in the past. The pain was chiefly frontal in location, and has been present more or less throughout the day except for brief intervals after taking aspirin. Pressure did not aggravate the discomfort; heat relieved it somewhat. The cough began soon after the headache appeared and has been present practically throughout the day. There has been a small amount of thin, whitish sputum, but no blood. Loss of appetite came on early and has applied to all kinds of food. There have been no other symptoms on the part of the stomach. The patient has had no actual nosebleed, but has noticed streaks of blood on his handkerchief on several occasions after blowing his nose.

COURSE.--In the ten days since the onset, the headache has continued severe until a few days ago, when it began to abate. The same has been true of the cough. Anorexia has persisted. There has been no epistaxis after the first few days. In addition, since the onset, the patient has noticed an increasing physical weakness with inability to concentrate on his work. It has been necessary, also, to employ enemata to obtain a bowel movement, although the patient was always regular in this respect. In the last day or two there has been what appears to be actual pain in the right lower quadrant of the abdomen; there has been no vomiting. The patient has felt feverish for the last week, and his temperature yesterday was found to be 103°F.

Previous
Illness:

PRESENT STATUS.--The increasing weakness has forced the patient to take to his bed. He says that he is satisfied just to be left alone. Aside from feeling very hot, drowsy, and uncomfortable, and being strongly averse to the sight and mention of food, he makes little complaint.

other pathological conditions almost too numerous to mention.

Malaria is another much abused diagnostic term. By carefully placed questions as to the place of residence at, or shortly before, the onset of the trouble, as to the duration, the treatment (quinin), etc., one is enabled to differentiate between this and other conditions with regularly recurring febrile manifestations.

The *neuritis* of the patient is seldom neuritis, being more commonly a subdeltoid bursitis, a tabes, a cervical rib, or what not. And what was diagnosed for one reason or another as *sciatica* proves to have been, or to be, sacro-iliac disease, hip-joint disease, flat-foot or some other condition.

Pain in the stomach, when analyzed, may prove to be appendicitis, renal or biliary colic, or one of the many other acute abdominal disturbances associated with pain.

Many patients describe *fever* as a symptom of the onset of their illness. Inquiry, however, very frequently shows that the individual did not use a thermometer, but merely felt feverish, while the course of the disease indicates that an elevation of temperature was probably at no time present. The same is true of *chill*; patients generally confuse a chilly sensation, such as occurs frequently at the onset of many acute infections, with a true rigor, as in malaria and pneumonia, in which the individual shakes the bed in the paroxysm and finds it difficult or impossible to get warm.

Pain in general is loosely employed to designate a great number of unpleasant sensations. Careful inquiry will usually elicit the nature of the "pain"—whether it consisted in a feeling of pressure, or of weight, in a burning sensation, a tired feeling, or an actual pain—a differentiation which is of extreme importance, for example in the diagnosis of gastric conditions.

Finally, as another illustration of the patient's incorrect use of medical terms, one might mention the ill-defined employment of the word *stomach*, which to the layman may mean anything from the diaphragm to the pelvic floor.

Examples of incorrect usage of medical terms by the patient might be multiplied almost indefinitely. Those given, however, are fairly illustrative and should serve as a warning to the beginner not to accept at face value the greater number of the patient's anamnestic statements.

No single feature of history-writing is as important, perhaps, as what has been termed *the analysis of symptoms* given by the patient. No history can properly be called such unless the factors qualifying each complaint are fully amplified and arranged to throw the greatest amount of light upon the symptom in question. In putting questions designed to bring out these qualifying details, the knowledge of pathological complexes has an unlimited field, and, as has already been mentioned, the medical training and experience of the examiner may be fairly judged by the extent to which he rounds out the setting of the important symptoms.

The student must, at first, learn to ask questions which are based not upon clinical experience alone, but obviously essential, one might say, even to the intelligent layman. If a patient complains of *loss of weight*, it is natural to ask him how great the loss has been, over how long a period the weight has been declining, whether the loss has been constant or has been arrested by temporary gains, whether a change of clothing or use of different scales from time to time may not have been factors, whether a change in work or working hours has taken place coincidentally with the falling off in weight, and so on. Later, with each year of added clinical experience, questions based upon a knowledge of conditions associated with a loss of weight can be added, questions, for example, calculated to indicate the possibility of the causative factor being tuberculosis, Graves' disease, malignancy, diabetes, etc.

The following illustrations will serve to give the reader an idea of what the author considers to be an analysis of symptoms:

*Symptom—Pain in the stomach:**Analyzing Questionnaire:*

- (1) Where is the pain, in the stomach or the region of stomach, distinctly to the right of the median line (duodenum, gall-bladder), over the appendix, substernal or elsewhere? Answers seem to indicate that the pain originates in the gastric region.
- (2) Is the complaint actually one of pain (like that due to toothache, a bump on the shin, a blow on the nose) or does inquiry show it to be a burning sensation, a feeling of pressure or weight, a grinding sensation, a feeling of emptiness, or even nausea? If pain is present, is it colicky, boring, dull, sharp or pulling? Some observers regard an actual pain as highly suggestive of an organic gastric disorder, as contrasted with one of a functional nature.
- (3) How long has the pain been present, and has it been constant or periodic since its onset?
- (4) Is the pain present throughout the day, or is it dependent upon some particular event of the day, such as mealtime, or the period before meals, or late at night?
- (5) If the pain is related to the taking of food, how long after eating does it appear?
- (6) Does the pain depend upon the kind of food taken, following, for example, the ingestion of coarse foods and not of soft or liquid kinds, or occurring after the ingestion of very hot or very cold articles, but not after those of a moderate temperature?
- (7) Is the pain relieved by the taking of food and, if so, by what types of food?

- (8) If vomiting is an associated symptom, is the pain relieved thereby?
- (9) Is the position of the pain constant, or does it radiate, and, if so, in what direction?
- (10) Does change of bodily position have an effect upon the occurrence or the severity of the pain?
- (11) Does bicarbonate of soda relieve the pain?

The above list of questions by no means exhausts the analysis of *pain in the stomach*. However, enough information may be obtained by the answers to this partial list to determine with a fair degree of accuracy: (1) whether or not the sensation complained of is actually a pain, (2) whether or not the location is gastric (or in the neighborhood of the stomach), (3) whether in connection with other features of the anamnesis—age, character of vomiting, loss of weight, etc.—a benign ulcer of the stomach is suggested, and its probable location, and (4) whether a duodenal ulcer is likely—late pain, night pain.

Analytical questioning such as the foregoing emphasizes very forcibly a point to which attention has already been directed, namely, that the fuller the experience of the examiner, the more profitably can he elaborate the various symptoms constituting the patient's complaint.

Symptom—Swelling of the ankles:

Analyzing Questionnaire:

- (1) Has the trouble been present before, and, if so, for how long, and how completely and under what treatment did it disappear?
- (2) If present before, was it more or less severe than at present?
- (3) Is the swelling constant, or does it disappear or recede, and when—mornings or evenings?

- (4) Has the amount of urine, or the frequency of urination, altered coincidently with the appearance of the swelling?
- (5) If fluid is also present in the abdomen, did the ascites precede or follow the ankle edema?
- (6) Is the swelling painful or red?
- (7) Is the edema unilateral, slightly or predominantly so, or bilateral?

The answers to these questions, especially when combined with information derived from associated symptoms (shortness of breath, vomiting of blood, hemorrhoids, headache, etc.) and from details of the previous illness (rheumatism, tonsillitis, etc.), and also from such etiological factors as alcohol, will serve to orient the examiner, to some extent, as to whether he is dealing with a general process, such as a renal or cardiac affair, a cirrhosis of the liver, or with some local condition, such as varicose veins or thrombophlebitis.

It is hardly necessary to illustrate further the manner of analyzing symptoms. In all, the method involved is the same, and while a finished analysis demands an extensive experience and a mature judgment, the young physician, by applying the principles involved, can elaborate a creditable and diagnostically helpful picture.

Previous Illness.—As already pointed out, what has been said concerning the accuracy of the patient's statements and the analysis of his symptoms is fully as applicable to diseases and symptoms which have existed in the past as to the details of his present illness. Also, from the point of view of form and coherence, it is probably advisable to exclude from the subdivision under consideration, Previous Illness, a description of previous attacks of the illness which brings the patient to a physician, inasmuch as these belong logically to the Present Complaint. Furthermore, it is a matter of custom, and promotes clarity, to consider past illnesses referable to the

venereal tract and the menstrual function under separate captions (*see* below).

Experience shows that a worth-while account of the patient's previous sicknesses is most likely to be obtained by asking him specific questions along set lines. To do this it is necessary to learn what conditions are apt to have sequelæ. The following are the most important, together with their more frequent complications:

- (1) Rheumatic fever (endo-, peri-, myocarditis).
- (2) Tonsillitis (cardiac and renal pathology; secondary focal processes, such as iritis, "rheumatoid arthritis," osteomyelitis, etc., etc.).
- (3) Typhoid fever (gall-bladder disease; osteomyelitis; myocardial degeneration).
- (4) Scarlet fever (nephritis, middle-ear disease and its complications).
- (5) Whooping-cough and measles (tuberculosis).
- (6) Pleurisy (tuberculosis). It is advisable to inquire as to the occurrence of pleurisy, pneumonia and "diseases of the chest" in general, for the light they may throw upon the thoracic findings later revealed by the examination, even though these findings may have no bearing upon the present illness.
- (7) Infections in general (cardiac and renal pathology).
- (8) Influenza—a waste-basket of disease called "grippe" by the patient (cardiac and renal pathology; chronic ill-health).

The above list of conditions is perhaps sufficiently inclusive as a routine; it does not, of course, embrace all diseases which may at one time or another have an etiological bearing upon the present illness of the patient. The individual case frequently requires an extra-routine line of questioning. For

example, in the case of a patient whose complaint is suggestive of a carcinoma of the stomach, it would be indicated to inquire specifically as to the occurrence in earlier years of a symptom-picture permitting the presumptive diagnosis of gastric ulcer, of which the patient had remembered only a few hazy details catalogued in his mind as "indigestion." Or, if the present complaint and findings speak for an hepatic or subphrenic abscess, it would be highly important to discover that at an earlier period there had been symptoms which at the time made little impression upon the patient, but which analysis shows to have been manifestations of appendicitis (called "stomach ache" or dyspepsia) or of a dysentery (described as diarrhea).

In addition to specific inquiry as to the diseases enumerated above, and questioning along less routine lines as dictated by other phases of the anamnesis and by the examination of the patient, it is also advisable to question the patient concerning symptoms which may have been noted at an earlier day. In sharp contrast to those individuals who consult a physician at the very inception of a symptom are those—and their number is not small—who overlook and forget manifestations which are not serious enough to compel them to go to bed.

Among the more important of such past symptoms of disease, which should form a part of the routine questionnaire and be analyzed as are the symptoms of the present complaint, are the following:

- (1) Headache.
- (2) Swelling of the ankles.
- (3) Cough.
- (4) Expectoration of blood.
- (5) Vomiting, and vomiting of blood.
- (6) Anomalies of urination and of the urine.
- (7) Shortness of breath.
- (8) Pain in the chest.

- (9) Pain in the abdomen.
- (10) Constipation and diarrhea.
- (11) Marked changes in weight.
- (12) Jaundice.

It is not within the province of this volume to discuss the diagnostic data which may be obtained from inquiries directed along these lines; their value becomes increasingly evident with the medical progress of the student.

The patient is questioned, finally, as to *trauma* and *operation*. In many cases, when the relation of one or the other of these factors to the present illness is self-evident, the patient has already mentioned them. In the case of slight trauma, however, it is often difficult or impossible to obtain a history of its occurrence, even though the picture strongly suggests it (sarcoma, bone tuberculosis). The details of a previous operation may throw light upon a condition in one of two ways: they may either account etiologically for the present illness (postoperative infection, adhesions, lung abscess following tonsillectomy) or, when the work has been done and recorded by a competent pathologist, they may explain the manifestations which have brought the patient to the physician. For instance, a former operation revealed a hypernephroma which has given rise to the present multiple bone changes; or, at operation for suspected peptic ulcer, the abdominal contents were found to be normal, in view of which the present (recurrent) gastric disturbances are probably functional.

The relationship of injury to the present illness may be obvious (fracture, rupture of the bladder, etc.) or it may be highly probable (jacksonian epilepsy due to injury to the head rather than to brain tumor, sarcoma of an extremity following a single trauma). Trauma also opens up the wide domain of neurasthenic and hysterical conditions in which the examiner is put upon his mettle to detect malingering in its bearing upon personal injury law-suits.

Family History.—While almost general unanimity exists as to the hereditary tendency of certain diseases, there is a considerable diversity of opinion as to whether or not a number of other conditions run in families. Two processes in particular must always be specifically inquired into, namely tuberculosis and cancer. This is not the place to discuss the genuinely hereditary nature of the former; suffice it to say that actual transmission via the sperm, the ovum or even the placenta is extremely rare. In the last analysis, *tuberculosis is largely a disease of propinquity*. The disease tuberculosis, furthermore, must be sharply distinguished from tuberculous infection. The evidence is all in favor of the view that between the ages of six months and fourteen years practically all of us are infected by tubercle bacilli; however, the great majority of us, fortunately for the human race, are able, for one reason or another, to check the process clinically. A minority, not endowed with efficient protective forces, succumb during that early period to the disease tuberculosis.

After this preliminary infection, a number of factors determine whether or not the infection will be lighted up into active disease. The individual born without a family taint will not, under ordinary conditions, contract tuberculosis, even though he is exposed to an open case for a long period. The same individual will probably not be affected by such predisposing diseases as whooping-cough and measles. If he is an alcoholic, however, or in a non-resistant state from other causes—diabetes, malnutrition, etc.—any natural immunity he may have may be cancelled. In other words, in the case of the individual with little or no tuberculosis in his family history, unless certain very pronounced predisposing factors are present, tuberculosis is relatively little to be feared, even though the element of exposure to open cases is at hand. This is one phase of the matter of the family history in its relation to the question of tuberculosis.

In the case of the individual from a tuberculous family, however, things are quite different. His constitutional makeup is such that exposure to open cases is positively dangerous, and pertussis and measles are real menaces. A big factor in the two types of individuals is, naturally, that the one must go out of his way, so to speak, to expose himself to the tubercle bacillus, while the other is born and raised in its presence.

All of these various factors must be taken into consideration when the patient is questioned in regard to tuberculosis. If there is no family history of the disease the chances are that the present complaint is not tuberculosis unless one of the above-mentioned predisposing conditions is present. An alcoholic from a family in which there has never been a case of tuberculosis is as likely to contract the disease as is a non-alcoholic who is constitutionally predisposed and has remained in his infected milieu. Another point of importance is the length of time during which an individual with a "bad" history has remained in the infected surroundings. For example, even if both parents and several brothers or sisters have succumbed to the disease, provided the patient himself was taken at an early age from his unhealthy environment and has followed a careful, hygienic routine, his chances of having escaped without mark may be considered excellent.

The foregoing remarks are by no means without exception and have been made solely for the purpose of showing, first, how little real information is to be gained merely by asking the patient whether or not there has been tuberculosis in his family, and, second, how many and how varied the conditions are which predispose an individual to the disease.

In the case of cancer, the situation is quite different. The tendency of carcinoma to run in families is generally recognized and must always be assigned due importance in the taking of the history.

There is a considerable difference of opinion as to whether or not the predisposition to a number of other conditions is handed down from one generation to the next. Some observers insist that the interrelated complex of contracted kidney, arteriosclerosis and arterial hypertension manifests a disposition to reappear in certain families; others that cardiopathies show a similar disposition. However, our ever increasing knowledge of the infectious nature of this latter group would seem to render this theory rather hazardous, unless we assume that the members of certain families inherit cardiac structures especially susceptible to infection. Perhaps even less definite is the matter of gout in this regard. Thus, in spite of the fact that in somewhat over one-half of the cases parents or grandparents have been affected, it is difficult to say whether a uratic disposition has been inherited or whether the son eats and drinks as did his father and grandfather.

There are two conditions in which the hereditary factor is very pronounced but which scarcely require investigation in the average case. These two diseases are hemophilia and insanity. We must inquire as to the former particularly before subjecting a patient to a surgical operation. In the insanities, heredity plays a very great role, and the history of a family predisposition may be of considerable help in the diagnosis.

Diabetes also exhibits a marked hereditary tendency, and although such a history may have little diagnostic value, it should be sifted in the glycosuric individual, from the point of view of statistical interest.

In certain diseases of the nervous system, finally, the family or hereditary factor may be of variable importance. Epilepsy, although probably not an inheritable affection in the great majority of cases, unquestionably occurs with great frequency in families of neurotic taint (hysteria, insanity). Chronic alcoholism in the parents also plays an important part in the production of, or predisposition to, epilepsy in the offspring.

Affections of the motor tract, especially progressive neural muscular atrophy and the muscular dystrophies, are frequently familial; hereditary spastic paraplegia and hereditary ataxia (Friedreich's ataxia) tend to be familial rather than hereditary conditions. Syringomyelia is occasionally a family disease; amaurotic family idiocy (Sachs' disease) is characteristically so.

Personal Routine (*Habits; Personal History*).—The term *personal routine* is suggested in preference to the more commonly employed *personal history*, or *habits*, because it more nearly describes the data included under this caption of the anamnesis. One or more of the points about to be discussed may have been fully analyzed in connection with the Present Complaint; in this case, repetition under the heading of Personal Routine will of course be unnecessary.

Each patient should be questioned specifically in regard to the following items:

OCCUPATION.—It is not enough that the individual's occupation be noted at the beginning of the history; he must be questioned also as to the details of the conditions under which he works. These details include his working hours, the amount of time he allows himself between arising and beginning work, the time he takes, or is allowed, for luncheon, the conditions as to light and ventilation under which he works, and his personal feeling toward his work. In occupations, furthermore, which have a special etiological bearing upon certain diseases—lead industries, for example—the patient must be asked concerning the precautions which the employer recommends to prevent lead-poisoning. Even excepting the so-called occupational diseases—those due to the various trades in which lead is used, as in the case of caisson workers, workers in phosphorus, etc.—the interrelationship of occupation and disease is in many cases very close. The subject is so large that a knowledge of its details must be gathered with the student's growing experience. As illustrations may be

cited: tuberculosis in carpenters, gout in bartenders, scurvy in cooks, myocardial degeneration in individuals who are constantly exposed to extreme temperatures (locomotive firemen and engineers) or to sudden changes in temperature (packing-house employees).

DIET.—The degree of detail with which this feature of the history is to be analyzed will depend entirely upon the nature of the complaint. In a case of pernicious anemia or ulcerative endocarditis, for example, the habits of the patient as to eating will scarcely add any information of importance. In diseases of the gastro-intestinal tract, on the contrary, the matter of the diet must be taken up in fullest detail. Inquiry must be made as to the number of meals eaten per day, the regularity of the meals, the quantity of food ingested, the general character of the diet, the peculiarities of the patient as regards very hot or very cold foods, highly seasoned dishes and foods which are particularly indigestible (pickles, cucumbers, hot breads, fried articles of diet), late dinners, banquets, etc. All of these items must be considered in relation to the particular complaints of the individual.

Many conditions require questioning along special lines in the matter of diet. In *angina pectoris*, for instance, it is important to learn whether the patient is in the habit of eating his heaviest meal at night, and whether he is given to indulgence in foods which tend to produce abdominal distention. In cases suggestive of *alimentary glycosuria*, the question of the amount of carbohydrates ingested is of prime importance. It is not difficult to understand why the patient whose diet consists chiefly of rye bread, herring and coffee may present himself with a well-developed case of scurvy, nor why the man who eats foods which leave practically no residue—eggs, meat, bread—and especially one who is a dainty eater, is likely to be troubled with *constipation*.

The author has merely touched the surface of this very large and important subject. The quantity, and especially

the quality, of the food have a very intimate bearing upon many disease processes. Some diseases, indeed, for example beriberi and pellagra, are in all probability due to dietetic errors.

BOWELS.—The average normal individual has one complete evacuation of the bowels daily. However, there are exceptions to this rule which may nevertheless be regarded as normal. One man, for example, may remain in good health with a movement every second day; another, with two moderately large movements daily.

The examiner must not be satisfied with the answer that the patient has a daily evacuation. He must ask also as to the size of the stool, and its character—whether it is normally formed, soft, mushy, hard and ball-like, etc. The analysis of the present complaint should have brought out such facts as tar-like stools, colorless stools, the passage of large amounts of mucus, painful defecation and the like.

Finally, it is well to ask in every case as to the use of cathartics—the kind, the frequency of use and the length of time during which they have been necessary.

ALCOHOL.—There should be no reserve in obtaining the facts as to the use of alcoholic beverages. Aside from the general importance of this subject, there are several special points which must be included in the questionnaire. In the first place, patients not infrequently say that they do not drink alcoholic beverages. Upon further questioning, however, they admit that they have not used alcohol for such and such a period—the beginning of the latter coinciding rather closely with the onset of their symptoms—but that previously they drank more or less excessively. Again, one not infrequently discovers that although the patient is not an alcoholic in the ordinary sense of the word, he has been addicted for a variable period to the use of certain patent medicines, the alcoholic content of which may be anything but negligible. Finally, information must be obtained as to the usual daily quantity

of alcohol taken, its quality (if whisky), its nature (beer, wine, whisky, absinthe), and as to whether the drinking has been steady or periodic.

EXERCISE AND RECREATION.—Although the saying "All work and no play makes Jack a dull boy" is old and threadbare, the truth it contains is always fresh. Other things being equal, the man who takes his outdoor exercise and vacation regularly is most likely to remain well. This has been demonstrated especially by the popularizing in recent years of golf. The man—and the woman—above forty who has previously begun to feel old and to need the services of a physician more and more frequently, has found something of what Ponce de Leon went so far to find.

It is an almost everyday experience for the physician to see a case which requires nothing so much as a change of surroundings or more exercise in the open. And this is neither the need nor the prerogative of the rich man alone.

DRUGS.—As in the case of alcohol, so with drugs, the physician should exercise no foolish reserve in putting direct questions. In many cases, mere observation of the patient—his approach, his speech, etc.—tells the whole story, rendering questions almost unnecessary. Opium, and its many derivatives, and cocain, are in the great majority of instances the drugs employed, in the sense of drug addiction. Morbid conditions may, however, not infrequently be traced to the regular use, even in moderation, of such substances as aspirin, antipyrin, acetanilid, etc.

SLEEP.—There is no hard and fast rule as to the time the average normal person requires for sleep. Eight hours may be regarded as sufficient for the majority of mature individuals. However, some require nine hours or even more to feel "fit," and others are satisfied with six or less. In many, if not most, cases as an individual gets along in years he finds that he needs much less sleep than the young adult. Also, toward middle life, many persons find that they have acquired

the habit of awaking very early in the morning and that they are ready to begin the day's work, irrespective of the hour at which they may have retired the night before.

Bearing these facts in mind, the examiner should inquire into the patient's sleeping régime—how long and how well he sleeps, and whether he awakens refreshed. One should inquire, finally, as to the conditions of temperature and ventilation under which the patient sleeps.

TEETH.—In view of the established importance of the condition of the teeth in the state of the patient's health, questions bearing upon the daily care of the teeth and the regularity with which the individual consults his dentist should form part of the routine in every case.

TOBACCO.—This item should be as carefully investigated as is the subject of alcohol, because of the many injurious effects of smoking upon the predisposed individual. Conditions of vascular spasm (angina pectoris, intermittent claudication), gastric disorders, insomnia, nervous disorders, involvement of the optic nerve, and cardiac irregularities are a few of the more important disturbances more or less directly attributable to the use of tobacco in excess or to the use of tobacco in any amount by hypersusceptible individuals.

OTHER FACTORS.—Finally, in certain cases, it becomes necessary to go into the matter of the patient's clothing, his sexual habits, his business or family worries and other details of his routine life.

Venereal History. —Syphilis and gonorrhea are the two venereal diseases concerning which specific questions are to be put. Different courses must be pursued, depending upon the sex of the patient. A man will as a rule admit readily enough that he has had one or more attacks of gonorrhea, especially if it is spoken of as "clap." It is more difficult, as a rule, to obtain a history of syphilis. This is not due to a desire for concealment on the part of patients, who fortunately have learned much through the medical propaganda of

recent years concerning the by-products of the disease, and are generally willing and even eager to give the physician all the information they can; it is rather due to ignorance either of the meaning of the term or of the fact that they have been infected.

It happens not at all infrequently, for example, that the chancre was intra-urethral and associated with a neisserian infection, and that the secondary manifestations were transient or practically absent. Many patients are perfectly honest and correct in their statements that they have never observed cutaneous manifestations; others have seen no reason to distinguish between a syphilitic sore throat and other anginas which they may have had from time to time. Extragenital chancres, and especially syphilis insontium, very frequently remain unrecognized.

The venereal history of the married male also includes information as to the health of the patient's children and as to any miscarriages which his wife may have had.

Syphilis is widespread and its sequelæ are extremely important. It is therefore fortunate that the case upon which the history throws an inadequate etiological light can be illuminated in still other ways. The author refers to the several laboratory methods of the last decade, namely the Wassermann reaction in the blood and in the spinal fluid—with a provocative salvarsan injection, if necessary—the luetin cutaneous reaction, and the study of the cerebrospinal fluid.

In the case of women patients direct questions as to syphilis and gonorrhea are generally omitted. Circumlocution is usually satisfactory. Thus, if the present complaint, reinforced by the local examination, indicates a salpingitis, the patient may be questioned as to a previous vaginal discharge—its color, thickness, duration, effect on the act of urination, etc. If syphilis is suggested by the history already taken, she may be questioned as to the occurrence of sore throat, exanthem, loss of hair, headache and other manifestations of the

secondary period. A woman rarely has knowledge of the primary lesion. The most important information, however, is obtained from the menstrual history, which includes questions concerning miscarriages (*see below*). Finally, as in the case of the male, if all of these leads yield nothing, the laboratory is the decisive recourse.

Menstrual History. —In the case of patients presenting themselves with a distinctly gynecologic complaint, the present and past details (including operations) bearing upon that complaint should be analyzed under the subdivision: Present Complaint (p. 27); in the remainder of the cases, all illnesses of pelvic origin are to be considered in the subdivision under discussion.

The following questionnaire applies to the menstrual function:

(1) The age at which the monthly periods began, the time which elapsed before the menses became regular, and the symptoms, if any, which marked the period of adolescence.

(2) The type of menstruation, i.e., twenty-eight-day type, thirty-day type, etc.

(3) The regularity of the menstrual flow.

(4) The amount of flow.

(5) The duration of flow.

(6) The symptoms present during the period.

(7) If the climacteric has taken place, the age at which it occurred, the symptoms of the transition, and the manifestations, if any, which have appeared since the change.

(8) The number of children born, if any, their ages and state of health; the number of children who may have died and the causes of their death; the number of miscarriages and their time relation to full term deliveries.

As has already been stated, important light as regards syphilis in the patient's anamnesis is thrown by the history of miscarriages. Following marriage, if one pregnancy after another results in a miscarriage, each of which occurs at a

time somewhat later than its predecessor, one child being delivered dead at term and the next living only a short time, the evidence is practically complete that the mother has syphilis. Less marked variations of this sequence possess a significance only less important. One or more miscarriages scattered irregularly among full term deliveries of children who have survived and remained healthy have relatively little significance, so far as lues is concerned.

In the majority of cases, local conditions are naturally the basis of abnormalities revealed by the menstrual history. Many general states, however, are suggested by such anomalies, especially in the case of women in whom the menstrual function has previously been normal and who have not reached the age of the menopause. A few such general conditions may be cited, namely, tuberculosis, chlorosis, Graves' disease, myxedema and hypophyseal disorders (acromegaly).

CHAPTER IV

SYMPTOMS WHICH MAY BE NOTED BY THE EXAMINER WHILE HE IS WRITING THE HISTORY AND BEFORE HE HAS BEGUN THE EXAMINATION PROPER

At this point we shall consider, very briefly, certain matters which belong properly in the province of the physical examination and not in a volume devoted to the writing of histories. However, the author has thought it advisable to risk the criticism of encroaching upon the field of physical diagnosis in order to emphasize the preëminent importance of the education of the physician's sense of observation. Although it is no doubt true that the power to see manifestations in the patient is to some extent a gift not possessed by all, it is equally true that the man who tends to overlook what is obvious to another may still educate his undeveloped or neglected sense of observation to no small degree.

Perhaps by this emphasis the author can assist in correcting another failing all too common among practitioners, namely, that of resorting at once to palpation, percussion or auscultation, before the eyes have been given a chance to observe.

The following are among the more important points of information (the list is by no means an exhaustive one) which the physician may have been able to gather upon meeting the patient and during the preparation of the history, before he has begun the actual physical examination.

Mental State. —A very fair idea of the patient's mental condition should have been gained by the time the history has been written, provided, of course, his sensorium is such that he can answer questions. Indeed, the diagnosis of the psychoses and neuroses must, in great part, rest upon what the patient says and his way of saying it, supplemented, if need be, by the statements of relatives and friends.

Insanity, aside from quiescent periods which may be part and parcel of certain types, is usually easily recognized as such. The emotional side of *hysteria* will scarcely be held in complete abeyance while the individual is being questioned. There may be attacks of weeping, crying, laughing, perhaps cries which mimic the sounds produced by animals, as barking, mewling, etc., or even a characteristic convulsive seizure especially staged for the physician. The *neurasthenic* generally betrays himself by his low-spirited and despondent mien, which is apt to be reflected in his mode of approach and even in his dress; while as the recital of the history progresses, his all-embracing symptom-complex, his anxieties, his phobias, etc., confirm what observation alone has suggested. However, the author cannot refrain from digressing to emphasize that if the examiner wishes to avoid serious error he must not make his final diagnosis of hysteria or neurasthenia until the routine examination has been completed, for it not infrequently happens that one or the other of these conditions is superimposed upon the basis of an organic process.

As regards the patient's *sensorium* we either recognize the individual to be in full control of his mental faculties, or, on the contrary, we note the presence of such deviations from the normal as *coma*, which may be of different degrees, varying from the form in which the patient may easily be aroused to that in which unconsciousness is absolute; *delirium*, which may be quiet, noisy or mixed; or *stupor*, such as results from alcohol or opiates.

Mode of Approach.—Such information as may be derived from observation of the bedridden individual will be discussed below. The ambulatory patient cannot fail to make a very definite impression upon the physician, merely by his mode of approach. An erect carriage and an energetic gait point generally to some illness of a minor nature; a bent figure and a slow, calculated walk, to a serious illness or perhaps to mental depression. An unusual gait may clinch the diagnosis—or a

portion of it, at least—at a glance (tabes dorsalis, hip-joint disease, hemiplegia, paralysis agitans, etc.).

Facial Expression.—Data of great diagnostic value may be derived from a close observation of the patient's facial expression. First of all, conclusions as to his mental state (*see* p. 51) are based not only upon the content, mode of recital and coherence of his story, but also in great part upon the impression conveyed to the examiner by the play of his facial muscles. Intelligence and the varying degrees of lack of intelligence quickly reveal themselves by subtleties of expression. The hysterical grimace or purposeless smile are unmistakable, as are also the depressed mien of the neurasthenic.

The expression conveys also such subjective states as pain, anxiety, agitation, uneasiness and care, and gives one a very fair idea of the severity of the patient's illness. The face is furthermore a good index of the presence of fever, which is recognized by a characteristic luster of the eyes and a redness and turgidity of the skin; while the sick individual may in some cases appear peculiarly animated and in others extremely depressed and dull.

Also characteristic are the distress and anxiety of dyspneic patients, the hunted expression in the more advanced stages of pulmonary tuberculosis, the facies hippocratica of peritonitis, the mask-like face of Parkinson's disease, the risus sardonicus of tetanus, the adenoid facies, the acromegalic face (large features, prognathous jaw), and the absent play of the facial muscles in Bell's palsy.

Position in Bed.—Many diseases may be characteristically indicated by the position assumed by the bed-ridden individual. This is illustrated by the case of the *typhoid* patient, for example. After the nurse has given him his morning care, he will remain, until disturbed, in the position in which he is left, namely, flat on his back in the middle of the bed. The resemblance of one case of typhoid to another is truly remarkable. The individual with disease of the thoracic organs, on

the contrary, generally prefers to lie upon his side. Such a condition may properly be assumed to exist if the patient maintains the lateral posture when the physician enters the sick room and even when he is addressed. If pain dominates the picture, the sick man generally prefers to lie upon the unaffected side, as the weight of the body tends to increase the distress. If, on the contrary, the pulmonary function is limited (in pneumonia, fluid or air causing collapse of one lung), lying upon the involved side is preferable, as the healthy—or relatively healthy—side is unimpeded and can better do the work of both. In some cases, however, in which the pain and restrained breathing are more or less dependent one upon the other, the patient is likely to lie upon the side in which the pathology is located, as the body weight tends to act as a splint and thus limits the painful excursions.

In *cardiac disease* the patient may assume any of several positions, the comfortable one in the particular case being that in which the heart can best work under the disadvantages present.

In the severest grade of dyspnea—*orthopnea*—the patient can find a fair degree of comfort only by assuming the upright position, in a chair or propped up in bed, a position which gives the accessory muscles of respiration the freest play and allows the diaphragm to descend more readily, if fluid is present in the abdomen.

In *meningitis*, owing to muscular rigidity, certain constrained positions are common—*opisthotonos*, and more frequently, *orthotonos*. In conditions of peritoneal irritation, one or both thighs may be flexed to relieve the tension upon the psoas muscles, thus reducing the intra-abdominal tension—the right thigh in appendicitis, both in diffuse peritonitis. In some abdominal conditions associated with pain—colic, for example—the patient finds the greatest relief by lying on his abdomen.

Finally, in cases in which the history has made a tentative diagnosis possible, the tendency of the patient to remain in a given position may suggest the localization of the process. In saccular bronchiectasis, for example, one may be reasonably sure that the patient does not choose the position which provokes cough with its attendant large expectoration. In presumptive gastric ulcer we have at least the right to assume that if the right lateral position is the most comfortable one the ulcer is not in the neighborhood of the pylorus, or, if lying on the abdomen gives the greatest relief, that the ulcer involves the posterior wall of the stomach.

Examples of the diagnostic importance of the patient's position in bed or of certain constrained attitudes might be multiplied almost indefinitely; however, the illustrations cited give a very fair idea of what observation may reveal in this province.

Relation of Appearance to Age.—Almost involuntarily, the examiner tells himself that one individual looks his age, that another looks years younger than his age and that a third man appears considerably older than his years. The young-looking old man has in all probability taken good care of himself as regards food, tobacco, alcohol, exercise, etc., while the chances are that the old-appearing young man has indulged to excess in certain things recognized to be harmful. Factors causing exceptions to these presumptive diagnoses are previous freedom from illness, or the occurrence of considerable previous illness, respectively, and the tendency of the members of some families to retain a youthful appearance and of others to age prematurely.

State of Nutrition.—Although it is not possible to tell by observation alone whether the patient has *lost moderately* in weight or whether he has *gained* slightly or markedly in weight, it is generally not difficult to determine at a glance that there has been a *considerable loss* of weight. One may see this, perhaps, in the loose fit of the clothes, but more par-

ticularly in the shrunken appearance of the face, in the hollows about the face, and in some cases by the looseness of the skin of the face. Once it has been determined that the individual has lost a good deal of weight, the commoner causes of such a state (malignancy, tuberculosis, diabetes mellitus, Graves' disease) are automatically suggested to the examiner.

Some experience also enables the physician to judge whether the patient conforms approximately to the age-height-weight-sex ratio, or whether he varies from the ratio in one direction or the other.

Skin and Mucous Membranes.— Observation may yield considerable information regarding the skin and mucous membranes, even from those parts visible before the patient has prepared himself for examination. The color associated with good health need not be dwelt upon. It must not be supposed, however, because the skin is pale, that the individual is anemic, for although this is frequently the case, the pallor may be congenital and due to the narrow caliber of the cutaneous vessels. If the condition is distinguishable at the distance at which the physician sits from the patient, and if it is evident that the pallor involves also the lips, the lobes of the ears and the gums, then the diagnosis of anemia is justifiable. The interpretation of generalized abnormal coloring of the skin will of course be obvious—jaundice, cyanosis, pigmentation, etc.

Many diseases of the skin involve characteristically the covering of those parts (face, neck and hands) which are being considered in the visual examination. A few may be cited, such as acne, erythema multiforme, eczema, certain of the syphilids—the corona veneris, for example—herpes simplex, lupus erythematosus, and some of the contagious exanthemata (measles, scarlatina with its circumoral pallor, etc.).

Hair and Nails.—It may perhaps be noted that the *hair* of the head is fine and lustrous, or that it is coarse and dead (as

in myxedema). Seborrheic eczema is usually recognized at a glance from the branny scales on the hair, which may be either oily (oily seborrhea) or dry (dry seborrhea). Equally obvious are the alopecias—luectic, alopecia areata, and that most common form which generally defies a search for its cause and therapy. The characteristic lesions of psoriasis also may frequently be seen at the hair-line of the forehead.

The *nails* may also show a great deal. The care bestowed upon these appendages throws a good deal of light upon the habits of the individual. The nails of the worker in lead often strikingly indicate the reason why a particular individual has been poisoned by the metal. Many diseases involving the skin likewise leave their mark upon the nails (eczema, syphilis, psoriasis). Blueness of the nails associated with clubbed fingers will be mentioned in another place.

The Lymph-nodes.—The cervical chains of nodes are the only ones visible as the patient's history is being written, and these must have attained a certain size before they attract attention. Among the characteristic pictures at once suggested to the experienced eye are the collar of glands in Hodgkin's disease, and the enlargements, with fistulæ, of tuberculosis.

Vasomotor Disturbances. —The patient whose hand is shaken in greeting may at once betray the instability of his vasomotor system by his moist grip; or, he may frequently wipe his hands with his handkerchief during the course of the questioning. Another manifestation of this same instability is the flushing, or alternate paling and flushing, seen in the faces of some patients.

Cough and Expectoration. —A very fair presumptive diagnosis can often be made from a close observation of the type of cough or the character of the expectoration of some individuals, if the physician is present at a favorable moment. The brassy cough of aneurysm of the aorta or of some other mediastinal tumor, the whoop of pertussis, the hollow, toneless

cough of advanced tuberculosis, and the productive cough of pulmonary cavities, brought on by a change of position, may be cited as illustrations.

If the patient expectorates during the preparation of the anamnesis, the physician is often enabled to obtain much information from the character of the sputum. One suspects pulmonary softening (abscess, tuberculosis) if a large amount of purulent material is brought up at frequent intervals; bronchiectasis is indicated if the expectoration is "mouthful"; lobar pneumonia when the sputum is rusty; tuberculosis, or perhaps cardiac disease, when the material is blood-streaked, and gangrene when the never-to-be-mistaken odor is present.

The Breathing.—The orthopnea of decompensated hearts has already been mentioned. Other characteristic types are the dyspnea, with expiratory grunt, of pneumonia, the expiratory difficulty of emphysema, the inspiratory dyspnea, with recourse to the accessory muscles of respiration and fixed position of the spine and arms, in stenosis of the upper air-passages (diphtheria, foreign body), the asthmatic type with its easily-heard wheeze (true bronchial asthma, cardiac and renal disease), the air-hunger of diabetic coma, and the Cheyne-Stokes type of breathing occurring particularly in uremia and in cardiac and intracranial conditions.

The Voice and the Speech.—The severely ill or extremely weak individual generally betrays his condition by his voice; the tonal quality of the latter suffers also in dyspneic states. The "thick" voice of chronic alcoholism, furthermore, is quite distinctive. Ulcerative processes (syphilis, tuberculosis, cancer) involving the cords give to the voice a raucous quality that is unmistakable. Paralyses of the vocal cords produce an aphonia which must at once guide the trend of the examination.

The speech of certain diseases (multiple sclerosis, general paresis, and bulbar paralysis) may also be characteristic.

The Eyes.—During the process of the history-writing the physician may observe few or many eye symptoms, depending upon how close he is to the patient, and how favorable the light is. When one or more extrinsic muscles are paralyzed the fact is of course obvious, although the examination proper must determine the details of the paralysis. The same is true of an injection of the visible blood-vessels, i.e., the redness of the eye may be due to conjunctival or to circumcorneal injection, which the later examination must reveal, as well as determining the cause of the injection (foreign body, type of organism, etc.).

Cataract is often recognized at a glance. Inequalities of the pupils of sufficient degree are also frequently evident in a good light. Unilateral or bilateral exophthalmos is, of course, obvious. In addition, mere observation is sufficient to make a diagnosis of a number of diseases of the external eye which need not be enumerated here.

The Ears.—Defective hearing in both ears is quickly noted; if, however, only one ear is involved, practice may have made the patient so proficient in concealing the weakness by the use of the sound, or sounder, ear, that the fact may escape the examination by observation.

Observation may also not infrequently reveal the presence of gouty tophi in the ears.

The Teeth.—Information as to the teeth may in some cases be obtained by observation alone, particularly in the case of individuals who have a habit of showing their teeth. Notched incisors, ulcerative conditions of the gums, missing teeth, and pyorrhea, are among the conditions which may occasionally be revealed by an examination carried out under the limitations imposed.

The Breath and the Body Odor.—The ordinary bad breath, although frequently evident even at a distance, indicates only one of a number of possible causes. Certain breaths, on the other hand, are highly significant. Of the odor due to

the recent drinking of alcohol, nothing need be said. Just as characteristic, although not easy to describe, is the breath of the chronic drinker. The fruity breath of the diabetic, due to acetone, is diagnostic, although it is said that all physicians are not able to appreciate this odor. The frightful odor of pulmonary gangrene baffles description. As another example of a diagnostic breath, finally, may be mentioned that of uremia, which is urinary in character.

Patients with certain diseases are said to give off body odors characteristic of those diseases. Among the latter are typhoid fever, small-pox and syphilis.

The Extremities.—The hands are visible in this examination, and characteristic symptoms or conditions may be observed in certain cases. Clubbed fingers—the broadening of the terminal phalanges with an exaggerated arching and cyanosis of the nail—indicate principally congenital heart disease and bronchiectasis, and less often other cardiac and pulmonary conditions. One may note also the red periarticular swellings of rheumatic fever, the deformed joints of subacute and chronic infectious arthritis, the chalky nodules of gout, Heberden's nodes, the large hand of acromegaly, the changes associated with Raynaud's disease, erythromelalgia, and thrombo-angiitis obliterans, the spindle-shaped enlargements of one or more digits due to tuberculosis or to syphilis and the "claw-hand" of paralysis of the median or ulnar nerve.

The Abdomen.—Observation reveals little regarding the abdomen, except the presence of considerable enlargement, the cause of which must be determined by the subsequent examination.

Edema.—As the patient, clothed, sits before the physician, the latter can observe edema of the eyelids, if present, edema of the entire face, swelling of the hands, swelling of the thighs and perhaps of the legs, if very marked, and finally edema of the ankles, if the individual presents himself with loosened shoe-laces.

Visible Nervous Manifestations.—Certain characteristic gaits have already been mentioned (p. 52). *Tremors* of various types may be observed in different localities. This symptom is perhaps most frequent in the hands, and the type of the movement in certain diseases may be very characteristic (paralysis agitans, multiple sclerosis, old age). A trembling of the eyelids is often seen in neurasthenia. Occasionally the patient is first seen at the beginning or during the course of a general convulsion. This may be of the epileptic type (tonic followed by clonic movements), of the tetanic form, as in tetanus, or of the jacksonian type in which the convulsive wave, beginning at one point—usually an extremity—progressively involves the entire body.

The large, incoördinated movements of chorea are at once noted, as are athetoid movements of the fingers and the spasms of the hands in tetany. That ominous symptom—*subsultus tendinum*, i.e., the leaping of the tendons of the back of the hands and wrists—is seen especially in typhoid fever. Habit spasms (tics) most often involve the face, throat and shoulders, although the hands may be affected.

Paralyses can frequently be made out by observation only. It is possible in some cases to say that the patient whose history is being written suffers from hemiplegia (the gait has already been noted), from monoplegia or paraplegia. Or one may observe that the paralysis is flaccid, involving a peripheral neuron, as in poliomyelitis, or spastic, due to a cerebral lesion. The former hypothesis is strengthened if considerable atrophy can be made out, the latter if the atrophy is not prominent.

In the foregoing pages the effort has been made to show how much valuable information may be derived from observation alone. All of the data contained in these pages can be stored away in the physician's mind during the progress of the history taking and before the examination proper has been started. It may be added that these data are by no means all-

inclusive, but are given only as the more important, perhaps, of the signs and symptoms to be gathered under these limitations.

In conclusion, it may be said that with a history taken and analyzed under the conditions discussed above, the examiner should feel that he has built a substantial foundation for his diagnosis.

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